INSTRUCTIONAL DESIGN AND ASSESSMENT

An Elective Course in Cultural Competence for Healthcare Professionals

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Objectives. To develop and assess a cultural competence elective course used to increase students' levels of awareness, acceptance, and understanding of the role of culture on healthcare perceptions.

Design. Classroom and at-home assignments were designed, small group discussions were conducted, and guest speakers were recruited to allow students to explore different viewpoints about other cultures.

Assessment. Student performance was assessed based on assignments and participation in class discussions. Student satisfaction with the course was assessed using a standard course evaluation form.

Conclusion. Participation in the course resulted in greater student understanding of cultural issues facing healthcare providers and in students feeling more capable of integrating cultural factors into patient care.

INTRODUCTION

The increase in the number of ethnic minorities in the United States over the past decade has been extraordinary. In 1990, whites made up 76% of the US population.[1] By 2004, that percentage had dropped to 67%.[2] Citizens classifying themselves as black or African-American increased from 12% to 13%, and those classifying themselves as Asian, Pacific Islander, or Native Hawaiian rose from 3% to 4%. People of Hispanic origin can, and do, belong to any of these groups. The percentage of the US population of Hispanic origin increased from 1.6% in 1990, to 14% in 2004.[1,2]

As the ethnic background of the US population has changed, so have the languages spoken in the home. In 1990, 86% of the US population spoke primarily English in their homes.[3] That percentage decreased to 82% by 2000.[4] Simultaneously, the percentage of people speaking Spanish in the home increased from 7.5% to 10.5%, and the number of those speaking some language other than English or Spanish increased from 6.5% to 7.5%.[3, 4]

With these changing demographics came an increased awareness of healthcare disparities in the United States. People of diverse racial, ethnic, and cultural heritage suffer disproportionately from cardiovascular disease, diabetes, HIV/AIDS, and every form of cancer. In addition, infant mortality rates are generally higher, and childhood immunization rates are lower among minorities in the United States.[5] To address these disparities and different perceptions of the healthcare system between groups, we must first understand some of the cultural forces behind them. Formal training in cultural competence can further this understanding.

Cultural Competence

While the above statistics refer only to race and language, these are only 2 factors that contribute to an individual's culture. Culture is defined as "a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that are shared among members of a particular group,"[6] and involves all aspects of life, including values, beliefs, customs, communication styles, behaviors, practices, institutions, worldviews, clothing, art, buildings, and food preferences.[7]

Cultural competence is a "set of congruent behaviors, attitudes, and policies that come together" that allow professionals to accept and accommodate cultures other than their own, and enable professionals to work effectively in situations where more than one culture is involved.[8] Cultural competence in healthcare is "the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs."[9]

The National Center for Cultural Competence maintains that, in order to achieve this goal, organizations must:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;

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- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve;
- incorporate the above in all aspects of policy making, administration, practice, and service delivery, and systematically involve consumers, key stakeholders, and communities.[5]

As an individual or organization attempts to meet all of the above criteria, they will pass through the 5 levels of cultural competence, as illustrated in Table 1.[10]

Rationale for a Course in Cultural Competence

In addition to the obvious need for all healthcare professionals to address the changing face of our country, as discussed in the Institute of Medicine's 2001 Report, *Crossing the Quality Chasm: a New Health System for the 21st Century*,[11] many of the large pharmacy organizations are encouraging the incorporation of cultural competence into the pharmacy profession. The American Pharmacist Association (APhA), the American Society of Health-System Pharmacy (ASHP), and the American Association of Colleges of Pharmacy (ACCP) all have policies or statements addressing the need for cultural competence training in the workplace and in the academic institutions.[9,12,13] In addition, the American College of Clinical Pharmacy's definition of "clinical pharmacist" includes the application of cultural principles in optimizing drug therapy.[14] All of these organizations have offered educational programming at their recent meetings and conferences on the topic. The current ACPE Accreditation Standards do not contain any requirements for colleges and schools of pharmacy to include any form of cultural competency training.[15] The new Standards, adopted January 15, 2006 and effective July 1, 2007, however, state specifically that a school's curriculum should include training in this area and prepare students to practice in a culturally diverse society.[16] The 2007 Standards also encourage a diverse faculty, staff, and student body, and require that practice facilities and

Table 1. Levels of Cultural Competence[10]

Level 1	No insight about the influence of culture on care.
Level 2	Minimal emphasis on culture in medical setting.
Level 3	Acceptance of the role of cultural beliefs, values, and behaviors on health, disease, and treatment.
Level 4	Incorporation of cultural awareness into daily practice.
Level 5	Integration of attention to culture into all areas of professional life.

pharmacy practice experiences offer students the chance to integrate culture into the treatment of a diverse patient population, which would also require that they receive some form of didactic training on how to do so. It is currently unknown how many pharmacy programs offer coursework in the subject.

DESIGN

Early in our new School of Pharmacy's development, several students approached the course coordinator with concerns about their ability to provide optimal pharmaceutical care to Georgia's changing population. The coordinator contacted colleagues across the country who shared this interest via the ACCP Ambulatory Care and Education and Training Practice Resource Networks' respective list-servs. Several respondents generously shared syllabi and resources that they had used in similar courses. The coordinator attended educational seminars addressing building a cultural competent practice at both the ASHP 2004 Midyear Clinical Meeting and the APhA 2005 National Meeting. The coordinator conducted an informal poll of the student body to determine interest in the course. Because no other courses addressing the topic are offered at the University, the course design is largely based upon the syllabi shared by faculty members at other schools of pharmacy across the country or on Internet-based materials, and upon the contents and structure of several books on the subject of culturally competent patient care, including Galanti's *Caring for Patients from Different Cultures*, Salimbene's *What Language Does Your Patient Hurt In?*, and Spector's *Cultural Diversity in Health and Illness*.[7,17,18]

Cultural Competence for Healthcare Professionals (PHA 4246) is an elective course that was designed to address the need for cultural competence training in a pharmacy curriculum. It was offered for the first time to third-professional year students in an accelerated, 3-year doctor of pharmacy program during the summer quarter of 2005. The educational outcomes of the course are to help develop in students the attitudes, knowledge, and skills necessary to:

(1) Assess cultural factors that influence the individual's, family's, and community's orientation to the health care system in the United States.

(2) Identify areas of potential conflict between health care providers and a patient's cultural beliefs and values, and explain selected cultural factors that could affect the relationship between healthcare providers and patients.

(3) Use knowledge of health-related cultural/ethnic beliefs, values, and practices to design

a plan of care for culturally and ethnically diverse populations.

The rationale for this course, as stated in the syllabus is: Culture, language, lifestyle, and disease states all have considerable impact on how patients access and respond to health care services. Additionally, healthcare practitioners' backgrounds will mold their own attitudes and beliefs. For these reasons, pharmacy students should be exposed to the viewpoints that can potentially differ greatly from their own, and learn how to accept and value them, prior to beginning clinical rotations.

Course Activities

Because it was an elective course, the course coordinator chose not to use examinations. Instead, course objectives would be achieved through active learning. Students were engaged in activities such as reading assignments, written evaluations, case studies, simulations, and guided discussions, and a large emphasis was placed on their exploration of their own attitudes and values.[19] A cap of 20 students was set for course enrollment, to allow for optimal discussions and in-class activities. Nineteen students enrolled during the summer of 2005. The lecture and discussion schedule is outlined in Table 2.

The grading system for the course is summarized in Table 3. Twenty-five percent of the course grade was earned by professional participation in the course, including completing assigned readings, contributing valuable input during in-class discussions, and taking active and enthusiastic roles in the various activities, such as the cross-culture simulation game that was played on the first day of class. This activity was an adaptation of the Bafa'bafa' game.[20] It involves students taking on the attributes of 2 different cultures and then interacting. The game illustrates how easy it is to misinterpret actions and exchanges when the rules are unfamiliar, and demonstrates the need for thought-out strategies when learning about a new culture.

After the game was complete, the students were instructed to record 5 aspects of life that defined their "culture" and set it apart from others. They were told that they could add to or delete from the list at any time, and were asked to share their lists at various times throughout the quarter. This activity was designed to promote self-assessment of culture, as well as communication, but was not graded.

Four pharmacy-specific written case studies accounting for 20% of the course grade (5% each) were written to give students a different perspective on issues that might seem mundane to them. Cases were developed using the course coordinator's own experiences in a community pharmacy setting. Each student had to answer a set of

Table 2. Lecture and Discussion Topics Covered in the Course *Cultural Competence for Healthcare Professionals*

- What is cultural competence?
- Empathy
- Sources of Discord in the Healthcare Community
- Ensuring Cultural Competence in Practice
- Use of Medical Interpreters
- Conducting the Culturally Sensitive Patient Interview
- Health Disparities
- Health & Illness Behaviors
  - Religion
  - African Americans
  - Latinos
  - American Indians
  - Soviet émigrés
  - Middle Eastern
  - Mental illness
  - Chronic illness and end-of-life
  - Sexuality

questions regarding the case studies, and their answers to the questions were then used to guide in-class discussion. Case study grades were assigned based upon the thoughtfulness of the students' answers and the amount of research they had conducted to derive their answers. The case studies included:

(1) Conflicting Values and Stereotypes: Two pharmacists feel differently about dispensing a drug that could be used as an abortifacient to a teenage patient. At the same time, the patient's father, of Middle Eastern descent, asks to know what prescription his 15-year-old daughter had filled. Purpose: to stress the importance of asking questions prior to making decisions/judgments and also to help students affirm what their own values are.

(2) The Religious Patient and Compliance: An African-American patient is concerned that if he takes his medications daily, as he has been directed to do, then his God and his pastor will think that he does not believe strongly enough that he will be healed. Purpose: to enhance communication skills and empathy as the students has to counsel this patient.

(3) When Cultural Competence and the Law Collide: A young Chinese man feels it is his responsibility to "protect" his mother from her new diagnosis of metastatic colon cancer, and, thus, does not want you to tell her anything about the medication. Purpose: to require the students to

Table 3. Grading System

Assignment/Activity	% of Grade
Professional participation	25
Case studies	
• Conflicting Values and Stereotypes	5
• The Religious Patient and Compliance	5
• When Cultural Competence and the Law Collide	5
• Taboos (Blood)	5
Study evaluation or book review	25
Community interviews	
• Practitioner	15
• Patient	15

research and learn what they can and can not do at the request of a patient and/or caregiver.

(4) Taboos (Blood): A Somali woman is nervous about having a routine blood test to diagnose anemia. Purpose: to allow students to explore various cultures' beliefs surrounding blood, as well as to enhance students' communication and empathy as they counsel the patient.

At the beginning of the quarter, each student selected either a piece of primary literature dealing with health disparities or a book dealing with issues of race, language, religion, chronic disease, or mental health and how those factors affect interaction with the healthcare system. If they chose an article, they had to evaluate both the content of the article and the design of the study, based upon the "Questions Used to Guide the Drug Literature Evaluation Process" found in the Pharmacy *Clerkship Manual: a Survival Manual for Students*.[21] The written literature evaluation was graded based upon how completely they answered these questions and the validity and thoughtfulness of their conclusions. If they chose a book, they had to discuss the book's impact on their views and beliefs, giving specific examples of events from the text that led to those changes. Both the literature and book reviews were required to be written, and 1 class period was dedicated to a group discussion of this assignment, with students sharing their thoughts and impressions. Students were graded on their participation in this discussion as part of their professionalism grades. This assignment accounted for 25% of the course grade.

The last structured activity contributing to the students' grades in the course was community interviews. Each student developed a culturally sensitive interview tool during the first 3 weeks of the quarter, utilizing the 8 questions developed by Arthur Kleinman[22]:

(1) What do you think caused your problem?
(2) Why do you think it started when it did?

(3) What does your sickness do to you? How does it work?
(4) How severe is your sickness? How long do you expect it to last?
(5) What problems has your sickness caused you?
(6) What do you fear about your sickness?
(7) What kind of treatment do you think you should receive?
(8) What are the most important results you hope to receive from this treatment?

Other important aspects of culture, as illustrated in Table 4, were integrated into the exercise, as the students were instructed that the purpose of this tool was to discover the impact the interviewee's culture had on the students' perceptions of the healthcare system, not necessarily to determine their perception about an illness. This tool was reviewed by the course coordinator, and then the students selected one patient and one practitioner in the community who fit a cultural profile different from their own (race, language, religion, sexuality, etc). The students turned in summaries of each interview and their own reflections in two 2-4 page papers. This assignment accounted for 30% of the course grade (15% each).

In addition to the above activities, several guest speakers were invited to participate in the course, including 2 medical interpreters and a social worker from the local Latin American Social Organization (LASO) branch, a Puerto Rican physician, and an African-American podiatrist. Faculty specialists in psychiatry and oncology led the discussions on mental illness and chronic disease, respectively.

ASSESSMENT

Evidence of student learning was provided by the students' assignments and their course assessments. The students evaluated the course based upon 10 "Course Core Items" that are applied to every course at the School of Pharmacy, and upon the educational outcomes, as presented in the course syllabus. The results of these evaluations are presented in Table 5. Thirty-three percent of students agreed, strongly agreed, or were undecided about the statement that the course covered too much material, and the same percentage of students disagreed, strongly disagreed, or were undecided about the statement that the course was intellectually challenging. Otherwise, the evaluations of the core items were very positive, with all students either agreeing or strongly agreeing with the statements regarding course objectives, grading system, audiovisual aids, and organization.

Evaluations of the educational outcomes showed that 100% agreed or strongly agreed that, after completion of the course, they could identify areas of conflict between

Table 4. Considerations for Conducting a Culturally Sensitive Interview as Part of an Assignment for a Cultural Competence Course for Healthcare Professionals

What is the patient's level of ethnic identity?
What is the patient's language and communication process?
What was the patient's migration experience?
What role does "self" play in the patient's culture?
What is the influence of religion and/or spirituality play in the patient's belief system and behavior patterns?
What are the patient's views and concerns about discrimination and institutional racism?
What are the patient's views about the role that ethnicity plays in daily life?
What is the patient's educational level and employment experience?
About what habits, customs, and/or beliefs is the patient comfortable speaking with you?
What importance does the patient place on physical characteristics?
How does the patient describe the influence of his or her culture on health beliefs and practices?
What is the patient's current socioeconomic status?

various cultures and the Western medical system, and all but 6.7% agreed or strongly agreed that they are capable of designing a care plan that integrates various cultural factors for patients in their care. That 6.7% were undecided on this outcome.

Student comments regarding the course were overwhelmingly positive. A majority stated that they enjoyed the variety of activities that were included, and felt that the less-structured atmosphere encouraged open discussions and even debate.

Suggestions on how to improve the course, which will be implemented in the future, included going into more detail on specific cultures and having more speakers throughout the course.

DISCUSSION
Course Outcomes

Student evaluations and comments suggest that the course was a valuable experience for the students who participated. The discussions were professional and thought provoking. One possible reason for the lively discussions, and a definite benefit to the course, could have been the diversity of the students enrolled in the course that semester: 6 black students (2 of whom were from Nigeria), 2 East Indians, 1 student of Hispanic origin, and 8 white students. Because of this diverse group, students were able to ask candid questions of individuals within their own class who were from other cultures and thereby learn from each other.

Table 5. Student Course Evaluation Results, % (N = 16)

Course Core Items	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
The course objectives were stated clearly.	87	13	0	0	0
The course objectives were related to lecture information.	87	13	0	0	0
The course objectives were reflected in the examinations.	N/A	N/A	N/A	N/A	N/A
The course grading system was explained adequately.	87	13	0	0	0
The activities contributed significantly to learning.	86	7	7	0	0
The course AV aids were valuable supplements.	86	14	0	0	0
The course was well-organized.	71	29	0	0	0
The course covered too much material.	7	7	20	27	40
The course was intellectually challenging.	47	20	20	7	7
The course built understanding of concepts and principles.	73	20	7	0	0
Educational Outcomes					
After completing this course:					
I can identify areas of conflict between various cultures and the Western medical system.	53	47	0	0	0
I am capable of designing a care plan that integrates various cultural factors for patients in my care.	33	60	7	0	0

NA = not applicable

The effect of a course such as this one on the community as a whole or on patient care has not been directly measured. However, comments from guest speakers were supportive and encouraging. A faculty member with a background in psychiatry who spoke in the course explained, "As pharmacists, we regularly serve people who have varying backgrounds, personal experiences, beliefs and expectations. We must have a sharp awareness of not only ourselves but also of how we are perceived by others. A course like this provides exposure to many patient populations which students may work with at some time in their career. Additionally, it shows students that their perception of a situation may be greatly different than the patient's perception." One physician stated, to the class as a whole, "This is wonderful! All students in all health professions should be required to take a course like this. It would progress practice so much, no matter what your discipline." He proceeded to invite the students to spend time at his busy obstetrics practice, where >85% of his patients are of Hispanic descent, and many do not speak any English. Unfortunately, none of the community pharmacists who were invited to speak were available. Thus, the effects on a practicing community pharmacist of being from a different culture were not emphasized to the students. While a goal for the course was to emphasize cultural differences and similarities, inviting dialogue and insight from guest speakers from different ethnic backgrounds and across health disciplines also stressed the importance of collaboration between members of the healthcare team, including the patient, by building upon the experiences and expertise of all.

Faculty Reflections

The course was a positive experience for the coordinator. The development of the course required extensive research, which allowed the coordinator to analyze and remedy some of the misinterpretations experienced in practice. Having no formal training on the subject, the coordiantor became aware of the possible barriers to care that can occur while conducting gestational diabetes education during a residency in Texas, where a majority of the patients were of Mexican descent. As mentioned previously, when the coordinator learned that students at her new teaching position had a concern about their abilities to offer culturally competent care, she began collecting resources and preparing the course. The enthusiasm of the students who enrolled in the course was gratifying, as they seemed to be genuinely interested in the topic and eager to share their own experiences. Since completing the course, numerous students have contacted the coordinator with examples of how knowledge and skills gained in the course impacted their clinical advanced pharmacy practice experiences.

Limitations and Lessons Learned

Initially, the class quickly reached full enrollment, as the students learned that there would be no examinations in the course. Once details about course structure and activities were released, however, 6 students withdrew, allowing 5 other students to enroll. The small class size, although limiting, as this type of training is useful to most students, was actually a benefit. The students were comfortable with the small group by the end of the course, and more open in their discussions. In the future, should there be enough interest, there is room in the curriculum to offer the course more than once a year.

This course has only been offered once, and, thus, only 1 set of course evaluations have been completed. Future evaluations will allow the course to be further honed to make it as useful for the students enrolled as possible. In addition to standard course evaluations, a competency-based skills and awareness assessment, similar to the one developed by Assemi et al, is necessary in order to evaluate the impact that a course such as this one has on students.[23] Administering this assessment tool during clinical rotations might prove even more useful, as students are applying the knowledge and skills gained in a practical setting. The experiential coordinator should add several outcomes specifically addressing the cultural competence of students on rotation to further assess the impact that this course had.

Because a majority of students will be going into community practice, it would have been ideal if the community pharmacists who were invited to speak had been available. In the future, it will be imperative to begin inviting speakers early enough to assure that this group is represented. The lack of participation from community pharmacists may reflect their discomfort with their own level of knowledge regarding cultural competence, demonstrating a possible need for training in this area within the community, especially among preceptors for the School of Pharmacy.

Where Do We Go From Here?

The course was a positive experience for all involved and warrants further development. In order to optimize the delivery of the course materials, faculty development specifically in the area of culturally competent patient care and teaching cultural competence would be extremely valuable, including on-campus workshops and making resources on the topic available in the library. The participation of numerous faculty members in the course could only expand perspectives and increase interest in the class discussions. As there are several healthcare-related

programs (physicians assisting, medical assisting, anesthesiology assisting) at the University, it would also be appropriate to open the course up to others, and have an interdisciplinary team teaching and enrolled in the course.

Many students suggested that the course be expanded to include more detail on individual cultures, which could be accommodated by offering the course as 2 sequential elective courses. Interest will be gauged prior to the next elective cycle to determine whether this would be desirable to the next class of students.

CONCLUSION

While a course such as this can introduce students to the concept of cultural competence, true (Level 5) cultural competence is an ongoing, time-consuming process. At best, this course promoted cultural sensitivity (Level 3-4). Hopefully, it encouraged students to further their training in the area, including instruction in another language, which was not included in the scope of the course. The positive experiences reported by the students, guest speakers from the community, and the course coordinator warrant developing this course further, possibly expanding it over more than 1 quarter to allow more in depth coverage of topics and to offer more students the opportunity to enroll in it.

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